

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7503	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2011
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NAME OF PROVIDER OR SUPPLIER MAYFIELD REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE SMYRNA, TN 37167
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During Annual Licensure Survey and Complaint Investigation Numbers TN26968, TN 28168, TN28270, and TN27823, completed on September 28, 2011, no deficiencies were cited under 1200-8-6 Standards for Long Term Care.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE 10/13/11

(X6) DATE

STATE FORM

6899

G8JU11

If continuation sheet 1 of 1

OCT 14 2011